Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOTEXAS PHYSICIANS SURGEONS
4780 N JOSEY LANE
CARROLLTON TX 75010

Respondent Name
WAUSAU BUSINESS INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-0701-01

MFDR Date Received
NOVEMBER 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per CCI edits code can be billed with modifier to differentiate between the services provided."

Amount in Dispute: $732.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2011	CPT Code: 26185-RT-59	$732.27	$518.31

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 16, 2011

   - B15- Payment adjusted because this procedure/service is not paid separately.

   - U008-This separate independent procedure is considered an integral part of the total services performed

and does not warrant a separate charge.

Explanation of benefits dated August 18, 2011

- B15- Payment adjusted because this procedure/service is not paid separately.
- U008-This separate independent procedure is considered an integral part of the total services performed and does not warrant a separate charge.
- X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Is CPT code 26185-RT-59 included in CPT code 26055-RT?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the submitted explanation of benefits the insurance carrier denied reimbursement for CPT code 26185-RT-59 based upon reason codes "B15- Payment adjusted because this procedure/service is not paid separately"; and "U008-This separate independent procedure is considered an integral part of the total services performed and does not warrant a separate charge."

   CPT code 26185 is defined as "Sesamoidectomy, thumb or finger (separate procedure)."

   Per NCCI edits, CPT code 26185 is a component of 26055 and a modifier is allowed to differentiate the service.

   The requestor states in the position summary that "Per CCI edits code can be billed with modifier to differentiate between the services provided." The requestor appended modifier 59.

   Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   A review of the operative report supports a separate procedure; therefore, the use of modifier 59 is supported reimbursement is recommended.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75010, which is located in Denton County.

CPT code 26185 is subject to multiple procedure discounting.

The MAR for CPT code 26185 in Denton County is $518.31. The respondent paid $0.00; therefore, the requestor is due $518.31.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $518.31.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $518.31 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		7/17/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.